Clear Form

FORM
N-172
(REV. 2003)

STATE OF HAWAII — DEPARTMENT OF TAXATION

Claim for Tax Exemption by Person with Impaired Sight or Hearing or by Totally Disabled Person and Physician's Certification

Part I Claim for tax exemption

INDIVIDUAL:

Name of Individual

Individual's Social Security No. | Spouse's Social Security No.

Street Address of Individual

City, State & ZIP Code

being (check applicable category)

☐ A person who is **blind** as defined in sec. 235-1, HRS,

☐ A person who is **deaf** as defined in sec. 235-1, HRS,

☐ A **person totally disabled** as defined in sec. 235-1, HRS,

CORPORATION, PARTNERSHIP, or L.L.C.:

Name of Corporation, Partnership, or L.L.C.

Federal Employer I.D. No.

Street Address

City, State & ZIP Code

all of whose shareholders, partners, or members are individuals who are (check all applicable categories)

☐ **Blind** as defined in sec. 235-1, HRS,

☐ **Deaf** as defined in sec. 235-1, HRS,

☐ **Person totally disabled** as defined in sec. 235-1, HRS,

hereby claim the benefits provided under the General Excise Tax and/or Income Tax Laws. (Check all applicable categories and provide the information requested. See separate instructions for the definitions of blind, deaf, and person totally disabled.)

☐ General Excise Tax (sections 237-17 and 237-24(13), HRS)

(a) License No. _____

(b) Doing Business As (DBA) _____

(c) Business Address _____

(d) Type of Business _____

(e) Individual's Percentage of Ownership: ` _____ ; Spouse's percentage _____

☐ Income Tax (section 235-54, HRS) (for individuals only)

(a) Name on tax return (if joint, show both names)

_____

NOTE: DISABILITY OR IMPAIRMENT MUST BE CERTIFIED BY LICENSED PHYSICIANS, OPTOMETRISTS, ETC., ON THE BACK OF THIS FORM.

I declare, under the penalties set forth in section 231-36, HRS, that I have examined/understand the detail contents of this claim and to the best of my knowledge and belief, it is true, correct, and complete.

IN THE CASE OF A CORPORATION, PARTNERSHIP, OR L.L.C., THIS FORM MUST BE SIGNED BY AN OFFICER, PARTNER OR MEMBER, OR DULY AUTHORIZED AGENT.

Signature | Date

Title

Applicant's Name _____ Social Security number _____

Part II Physician's or optometrist's certification. Complete only one section, even if applicant has multiple disabilities. **This form may be rejected if the appropriate section and the certification are not fully completed.** If Section A is completed, sign authorization for release of information below.

SECTION A — EYE EXAMINATION (Must be done by a qualified ophthalmologist or optometrist.)

1. Diagnosis _____
2. Vision 1) without corrective lenses: OD: _____ OS: _____ 2) with corrective lenses: OD: _____ OS: _____
3. Is this applicant's visual acuity 20/200 or worse in the better eye with corrective lenses: ☐ Yes ☐ No
4. Is the widest diameter of the field of vision less than 20 degrees? ☐ Yes ☐ No
5. Date first certifiable as legally "blind" (MM/DD/YYYY) _____
6. Should applicant be re-examined for tax purposes? ☐ Yes ☐ No If "Yes", when? _____

SECTION B — HEARING EXAMINATION (Must be done by a qualified otolaryngologist; i.e., Board-certified ear, nose & throat specialist, or a licensed audiologist.)

1. Diagnosis _____
2. Hearing loss (500-2000 Hertz) without aid: Right _____ Left _____ (Decibels ASA or ANSI 1969)
3. Is the applicant's average loss in speech frequencies (500-2000 Hertz) in the better ear, 82 Decibels ASA (or 92 Decibels ANSI 1969) or worse? ☐ Yes ☐ No
4. Date first certifiable as legally "deaf"(MM/DD/YYYY) _____
5. Should applicant be re-examined for tax purposes? ☐ Yes ☐ No If "Yes", when? _____

SECTION C — REPORT ON DISABILITY (Must be done by physicians as described in the definition for "person totally disabled" under section 235-1, Hawaii Revised Statutes.)

1. Diagnosis _____
2. Date individual became under your care? _____ Date individual first disabled or unable to work? _____
3. Is the individual totally disabled, either physically or mentally? ☐ Yes ☐ No
4. Is the disability permanent? (See "Person totally disabled" under Definitions in separate instructions.)
   ☐ Yes What is the effective date of disability? (MM/DD/YYYY) _____
   ☐ No When should individual be re-examined to determine extent of disability?(MM/DD/YYYY) _____
5. Is the individual able to engage in any substantial gainful business or occupation? (See "Person totally disabled" under Definitions in separate instructions.) ☐ Yes ☐ No
6. Pertinent symptoms or findings that preclude the individual's ability to engage in gainful work.

_____

CERTIFICATION BY PHYSICIAN, OPTOMETRIST, ETC.

I hereby certify that the above applicant conforms to the State definition of "Blind", "Deaf", or "Totally Disabled". Sign this certification only if the applicant meets the applicable definition.

Date of certification

Signature of Qualified Person As Described Above

Professional License Number Date License Expires

Print name of Qualified Person As Described Above

State/Other Licensing Authority

Address of Qualified Person As Described Above

AUTHORIZATION FOR RELEASE OF INFORMATION BY BLIND APPLICANT

I hereby authorize the Department of Taxation, State of Hawaii, to release my name, social security number, address, information on my eye condition and certification of my legal blindness as stated on tax Form N-172, to Ho'opono Services for the Blind Branch, Department of Human Services, State of Hawaii. The purposes of sharing this information are to maintain a State register of persons who are legally blind as mandated by section 347-6, Hawaii Revised Statutes, and to apprise me of services available from Ho'opono Services for the Blind.

Print Full Name of Blind Applicant Date

Address of Blind Applicant

Signature of Blind Applicant or witnessed X. If signed X used, two witnesses must sign

Social Security Number of Blind Applicant

Witness #1 - Signature, If X used.

Witness #2 - Signature, If X used.